MY OWN PLACE

817 Varnum Street, NE Suite 132 · Washington, DC 20017 · 202-636-2985 Fax: 202-526-7572
Kim Scott-Hopkins, Executive Director

November 20, 2007

Patricia W. VanBuren
Program Manager
Department of Health
Health Regulation and Licensing Administration
825 N. Capitol Street, NE 2nd Floor
Washington, D.C. 20002

Re: 3215 20th Street, NE

Dear Ms. VanBuren:

Enclosed please find the plan of correction for the Chapter 35 deficiencies noted during the monitoring survey that was conducted on 11/7/2007 at our Intermediate Care Facility for Mentally Retarded (ICF/MR) located at 3215 20th Street, NE.

We have addressed the concerns identified to maintain compliance with the regulatory requirements. Please note that the administration will continue to monitor this home to ensure that the individuals receive quality supports and maintain continual compliance.

If you need additional information, please let me know.

Sincerely,

Kim Scott-Hopkins
Executive Director

RECEIVED 11/21/07

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G027	A. BUILDING _____ B. WING _____	R 11/07/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{I 000}	INITIAL COMMENTS A follow-up visit to the annual relicensure survey was conducted at the GHMRP on November 7, 2007. Findings of the survey were based on observation, interview with direct care and administrative staff, and the review of records, as well as a review of resident and administrative records, including incident reports. My Own Place had made substantial progress toward correction of the deficiencies cited during the September 19, 2007 survey, however had continuing deficiencies as cited in this report.	{I 000}		
{I 090}	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: The GHMRP failed to maintained the environment as evidenced by the concerns identified in this section of the report. The findings include: Follow-up environmental observations were conducted at the Group Home for Mentally Retarded Persons (GHMRP) by the surveyor on November 7, 2007 at 11:50 AM. The surveyor was accompanied through the the GHMRP by the Qualified Mental Retardation Professional (QMRP). Observations are identified below: 1. The hardwood flooring in the hallway, directly across from the door of the half bathroom continued to not be tightly secured to the floor	{I 090}	1. Because the floor in question needs to be dug up and gutted out, these repairs will be done while the people supported are on a short vacation. The vacation is scheduled for the first week of December. The work will be completed by.....12-8-07. 2. The bathroom tubs will also be refinished while the people supported are on vacation...12-8-07. 3. The potential trip hazard caused by the metal tract at the bottom of the sliding door will be abated by...11-22-07. The QMRP and residence manager will conduct routine audits environmental audits and submit their findings to management for follow up on at minimum a routine bi-monthly basis...11-30-07.	

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{I 090}	Continued From page 1 underneath. This was evidenced by a section of the floor approximately 18 inches in length and the width of the hallway moving downward when one stepped upon. An additional area of raised hard flooring was observed farther down the hallway, in the area between the full bathroom and the residents' bedrooms. 2. The peeling paint observed on the interior surface of both bath tubs on September 19, 2007 had been removed from the bathtubs. Large areas of chipped paint however, remained on the interior surface of both bathtubs. 3. A metal tract was observed at the bottom of the sliding patio door between the living room and the adjacent room, where the laundry and medication administration areas were located. The tract created a potential trip hazard to the residents who had ambulation difficulties an/or were at risk for falls (Residents #1, #2, #3, #4 and #6). Further observation and interview with staff revealed that the exit door from the adjacent room led to the ramp which was located at the rear and side of the group home. It was also noted that Resident #3, who had severe ambulation difficulty, was observed ambulating on her walker to her wheelchair which was stored in the adjacent room.	{I 090}		
{I 206}	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties.	{I 206}		

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{I 206}	Continued From page 2 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff and consultants had current health certificates on file. The findings include: A follow-up to the September 19, 2007 relicensure survey was conducted at the group home on November 7, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) and the review of available records revealed that the three health certificates which were not available on September 19, 2007 continued to be unavailable. Interview with the QMRP on November 7, 2007 at 10:27 AM revealed that the names of the two staff (S1 and S12) and one consultant (C5) were needed to verify the status of their health certificates. Further discussion with the QMRP on November 8, 2007 indicated S1 (a direct care staff) and S12 (Licensed Practical Nurse) informed the administrative office that they had current health inventories, however forms were not sent to the provider by the physician as requested by the staff. A letter from the administrator dated November 8, 2007 revealed S1 and S12 were removed from the work schedule until they provide current health certificates. At the time of the follow-up survey a current health certificate was also not available for C5 (the Primary Care Physician).	{I 206}	Copies of the current health certificates for staff 1 and the PCP are attached ...11-19-07. The Director of Health Services continues to follow up with the relevant nurse who has indicated she will have a copy of her current health certificate by...11-22-07. The agency is in the final stages of establishing a database for monitoring personnel information. The HR coordinator will inform all staff of any personnel file issues that exist and also proactively notify staff about issues that are upcoming...11-30-07. HR will track and follow up on all such issues until each is resolved. MOP will take appropriate action against staff members that fail to update key information in a timely manner ...12-1-07.	
{I 222}	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel.	{I 222}		

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{I 222}	Continued From page 3 This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure continuous training programs was provided for all personnel. The findings include: 1. The GHMRP failed to ensure staff were effectively trained on interventions to minimize the risk of falls for Residents #1. [See Federal Deficiency Report -Citation W149, I] 2. The GHMRP failed to ensure staff were effectively trained on its established policy on seizure management for Client #1. [See Federal Deficiency Report -Citation W149, II]	{I 222}	See attached responses for W149, 1 and W149, II.	
{I 401}	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record verification, the GHMRP failed to ensure professional services were provided timely for one of the six residents residing in the GHMRP. (Resident #3) The findings include: The GHMRP failed to ensure health services were provided in accordance with the needs of Resident #3. [See Federal Deficiency Report -	{I 401}	See attached responses for W212 and W322.	

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(I 401)	Continued From page 4 Citations W212 and W322]	(I 401)		
(I 500)	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of the rights of four of the six residents living in the facility. (Residents #1 and #3) The finding includes: 1. The facility failed to develop and implement policies and procedures on health and safety for Residents #1. [See Federal Deficiency Report - Citations W149] 2. The GHMRP failed to ensure the rights of Client #3 to preventive care services. [See Federal Deficiency Report - Citations W212 and W322]	(I 500)	See responses for W149, W212 and W322.	

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{R 000}	INITIAL COMMENTS A relicensure survey was conducted from September 17, 2007 through September 19, 2007. The survey was initiated using the fundamental survey process. A random sampling of three clients was selected from a residential population of six females with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and two day programs, as well as a review of client and administrative records, including incident reports. The process revealed no deficiencies.	{R 000}		

Health Regulation Administration

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{W 000}	INITIAL COMMENTS A follow-up visit to the annual recertification survey was conducted at the group home on November 7, 2007. The facility continued to provide medical and habilitative services to six females with various disabilities. Based on observation, interview with direct care and administrative staff, and the review of records, including incident reports, My Own Place had made substantial progress toward correction of the deficiencies cited during the September 19, 2007 2007 survey. There were, however remaining uncorrected deficiencies as cited in this report.	{W 000}		
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system was established to obtain consent for treatments that may cause risks to the rights of one of three clients in the sample. (Client #3) The finding includes: A follow-up visit was conducted on November 7, 2007 to determine the status of the consent which was required for Client #3 prior to the completion of recommended medical procedures	{W 124}	The QMRP has identified a guardianship candidate for client #3 and has submitted her name to the DDS case manager. The DDS case manager has indicated that the candidate has been sent the necessary paperwork for guardianship status. Client #3 will visit the GI specialist on...12-4-07. At that time, the preliminary follow up will be done for the colonoscopy will be completed and a date for the actual procedure will be set. The QMRP will follow up with the guardianship candidate and the DDS case manager to insure that the guardian is in place in time to provide consent for the procedures. The QMRP's notes will reflect the status of follow up...12-12-07. The needed MRI will be completed at the same time while client #3 is properly sedated in order to maximize the likelihood of success...12-12-07.	

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{W 124}	Continued From page 1 (colonoscopy and MRI). a. Interview with the Qualified Mental Retardation Professional (QMRP) and the Licensed Practical Nurse (LPN) at revealed the colonoscopy to rule out GI neoplasm which was recommended during the May 24, 2006 GI consultation still had not been conducted. Further interview with the QMRP revealed the colonoscopy had not be completed due to the lack of an authorized representative to provide consent for the procedure. b. Interview with the QMRP and the LPN revealed the MRI with and without contrast which was recommended on September 7, 2006 by the neurologist to rule out seizure activity and dementia had not been conducted. Subsequent review of the client's clinical record at AM revealed no evidence that the recommended assessment procedures had not been done. Further interview with QMRP indicated that since the September 19, 2007 survey, she maintained contact with the case manager for assistance in obtaining an authorized representative to provide consent for Client #3's health procedures. Interview with the QMRP on September 19, 2007 at 12:19 PM revealed the affidavits had been forwarded to the Disability Services and the case manager for further action toward guardianship. The review of a correspondence from the Department of Disability Services dated November 7, 2007 revealed the guardianship package is being developed and will be forwarded to the hearing officer on November 8, 2007. The letter further stated that after approval, the	{W 124}	Only one other person supported in this home presents the same issues around medical consent support. That individual has a conservator who has voiced a willingness to also become the primary decision-making support person for medical decisions. The QMRP will follow up with the conservator of this individual supported to insure that client #4 has proper decision- making support in place for the future...12-15-07.	

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{W 124}	Continued From page 2 package will be forwarded to the court for review and for scheduling of a guardianship hearing. At the time of the survey, however, there was no evidence an authorized representative was available provide consent medical procedures (Colonoscopy and MRI) recommended for Client #3 to be completed.	{W 124}		
{W 149}	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensured the health and safety of one of three clients (Client #1) in the sample. The findings include: A follow-up survey was conducted at the group home on November 7, 2007 to determine the status of deficiencies cited during the recertification survey on September 19, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) and the review of training records revealed direct care staff were trained on adaptive equipment, and the ambulation protocol for Clients #1, #3 and #4 on October 5, 2007. Interview with staff and the review of records during the follow-up survey revealed Client #4 had sustained no falls since the September 19, 2007 survey. Client #1 however had sustained two injuries due to losing her balance as detailed below:	{W 149}	1. A team meeting will be held to determine if client #1 needs more intense or intrusive supports to prevent injuries from falls. Staff has been trained and does follow the existing protocol. The team will discuss whether that protocol needs to be modified to reflect closer (and more intrusive) monitoring parameters for client #1 when she ambulates and transfers. The team will also discuss whether she would benefit more from having a helmet than not having one. If the team agrees that she would benefit from having a helmet, the HRC will also review the consideration before a helmet is purchased or used...12-1-07. 2. The PT will review the walker currently used to determine whether it needs a larger seat or to be adjusted in any way to make client #1 safer when she uses the walker for walking support or to sit and rest for short periods...12-1-07. The existing protocols will be modified to insure that it clearly instructs staff to provide client #1 with hands on support if needed and verbal cues to safely sit and rest using her walker. Protocol modified by...11-30-07. Staff trained on modifications by...12-15-07.	

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(W 149)	Continued From page 3 I. The facility failed to minimize Client #1's risk of falls. 1. The review of a nursing progress note dated October 10, 2007 at was observed with an episode of seizure at work that lasted 15 seconds. The progress noted further stated that the client had another seizure episode in the bathroom at the group home while washing her hands. The nurse documented that slight swelling was observed on the left temporal. Review of the seizure log revealed the seizure occurred at 6:50 PM and lasted for thirty seconds. The review of an unusual incident report (UIR) dated October 10, 2007 revealed at 5:25 PM during a seizure, Client #1 fell against the bathroom wall causing some swelling of the left temporal area of her head. The nurse performed a neurological check, administered Tylenol 650 mg, and observed normal range of motion in all extremities. The addendum to the incident report reveal staff indicated the incident could not have been prevented. 2. The review of an UIR dated November 5, 2007 at 11:40 PM revealed Client #1 was transported to the emergency room by Emergency Medical Services (EMS) due to a seizure which lasted seven minutes and 37 seconds. The review of the seizure log indicated that the seizure occurred at 11:24 PM. Staff monitored the client during the seizure and telephoned 911. EMS arrived, assess the client and transported her to the emergency room for further evaluation. Interview with the QMRP and the record review revealed the client was treated at the ER and later released in stable condition to the group home at approximately 3:00 AM on November 6, 2007.	(W 149)		

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{W 149}	Continued From page 4 A second UIR dated November 6, 2007 revealed at 3:45 AM staff was escorting Client #1 back into the group home. While being assisted by staff to the house, the client slid from the seat of her walker to the ground. During the fall, she sustained a bruise on the right side of her lower back. The addendum to the incident report revealed staff documented that the incident could not have been prevented. Interview with the QMRP on November 7, 2007 indicated that the client sat down on her walker seat quickly before firmly placing her hips on the seat, which may may have caused her to fall. There was no evidence the GHMRP implemented effective measures on the aforementioned date to minimize Client #1's risk of falls. II. The facility failed to implement its established policy on seizure management for Client #1. 1. The review of an unusual incident report dated November 5, 2007 at 11:40 PM revealed Client #1 had a seizure which lasted seven minutes and 37 seconds. 911 was called, assessed the client and transported her to the emergency room (ER) for further evaluation. She was treated and released to the group home. Interview with the QMRP on November 7, 2007 at 6:40 PM indicated that the Neurologist recommended that the client be taken to the emergency room for post seizure monitoring if she had a seizure that lasted for more that five minutes. Further interview with the QMRP indicated that the primary care physician and the Neurologist agreed upon this exception to agency policy on seizure management for Client 3. The QMRP further indicated that the exception	{W 149}	It should be noted that My Own Place did not change its policies and practices for client #1 as it pertains to seizure follow up despite the feedback from the Neurologist. MOP policy calls for staff to call 911 if a seizure lasts more than 3 minutes. Staff followed this rule for the seizure situation cited. Client #1 had a seizure while in her walker. Two staff members assisted her to a supine position on the floor so that she would be safe. One stayed with client #1 to monitor and support her during the seizure. The second staff member called 911 as per MOP's policy and within the first 3 minutes of the seizure activity. The health management team of client #1 will meet to discuss whether there will be any modification in the existing 911 (seizure) notification policy, specifically for client #1. The Neurologist's feedback will be sought anew for the team's discussion. If a change is made, the existing protocol will be modified and staff will be re-trained on the modifications...12-15-07. The Health Management Care Plan for client #1 has been modified to reflect appropriate follow up for seizures, consistent with existing MOP policy...11-22-07. The HMCP will be modified further if necessary based on the decisions made by the health care management team on this issue...12-15-07.	

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{W 149}	Continued From page 5 occurred because past changes to the client's seizure medication regimen during ER visits after three minute seizures had been detrimental to the client. Documentation was requested from the QMRP to verify the approved length of time for Client #1 to remain in the facility after a seizure before calling 911. Interview and record at the time of the survey revealed this information was not available. The review of the client's health management care plan dated 12/06/06 also revealed that it did not include this information. The review of the agency's policy on seizure management revealed if a client has a seizure "Call 911 if seizure lasts longer than 3 minutes ". There was no evidence the an exception to the policy had been documented, reviewed or approved for Client #1's seizure management. 2. The review of the seizure activity form (log) on November 7, 2007 revealed Client #1 had a seizure on October 12, 2007. Further review of the log revealed the following information should be documented concerning the seizure: a) description of the seizure b) body movements c) behavior after the seizure d) time of day e) duration of the seizure f) staff initials According to the seizure record, the client was conscious and confused, however no further information was documented regarding the seizure. The review of the agency's seizure policy revealed all seizure activity must be	{W 149}	A nurse observed the seizure cited and wrote a progress note about it but did not complete the required seizure activity form. The nurse will receive training via the Director of Health Services or her designee on insuring that a Seizure Activity Form is completed whenever a seizure is observed...11-30-07. Lead RNs will review the medical records at minimum monthly to insure routine compliance for #3 above and to insure all documentation required is full and complete...12-1-07.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	09G027	A. BUILDING _____ B. WING _____	R 11/07/2007

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{W 149}	Continued From page 6 appropriately documented on the seizure activity form. There was no evidence documentation was maintained for the seizure on October 12, 2007 in accordance with the agency's seizure policy.	{W 149}		
{W 212}	483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure a comprehensive assessment to rule out seizure activity and dementia for one of three clients in the sample. (Client #3) The finding includes: A follow-up visit was conducted on November 7, 2007 to determine the status of the MRI which the neurologist recommended on September 7, 2006 for Client #3 to rule out seizure activity and dementia. Interview with the Qualified Mental Retardation Professional (QMRP) and the Licensed Practical Nurse (LPN) on November 7, 2007 at 9:37 AM revealed the MRI with and without contrast which was recommended by the neurologist had not been conducted because the client did not have an legally authorized representative to give written consent for the sedation which was required for the procedure. [Note: The review of the medical record review revealed a prescription for an MRI with and without contrast to be performed on September 25, 2006. The consultation report revealed that the client would not hold her head still to have the MRI performed. The radiologist recommended	{W 212}	As indicated, the plan is to obtain the MRI at the same time the colonoscopy is done for client #1 when she is properly sedated. This will maximize the likelihood of success and minimize the number of times she has to be sedated...12-15-07.	

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{W 212}	Continued From page 7 that the client be sedated to complete the procedure. Further review of the medical record review revealed the client also went for the MRI on February 27, 2007, however the procedure was rescheduled due to the client's late arrival. A radiology consultation report dated March 6, 2007 revealed "Patient can't have MRI of brain. She can't hold still nor follow instructions." The review of unusual incidents on September 17, 2007 revealed Client #3 was transferred to the hospital on October 20, 2006 via 911 due to an sudden episode of syncope and lethargy while eating. She was admitted to the hospital where she remained for treatment until October 23, 2006.]	{W 212}		
{W 322}	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide preventive and general medical care for one of the three clients in the sample. (Client #3) The findings include: A follow-up visit was conducted on November 7, 2007 to determine the status of preventive and general medical care deficiencies cited during the September 19, 2007 recertification survey. 1. The facility failed to ensure that Client #3	{W 322}	See responses for W124.	

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{W 322}	Continued From page 8 received a timely colonoscopy as recommended to rule out a GI neoplasm. Interview with the Qualified Mental Retardation Professional (QMRP) and the Licensed Practical Nurse (LPN) on November 7, 2007 at 9:55 AM revealed the colonoscopy to rule out Gastrointestinal (GI) neoplasm which was recommended during the May 24, 2006 GI consultation still had not been conducted. Further interview with the QMRP revealed the colonoscopy had not be completed due to the lack of an authorized representative to provide consent for the procedure. A nursing progress note dated March 5, 2007 revealed the client needed the colonoscopy screening for constipation and blood in stool. Interview with the RN and the QMRP on September 19, 2007 revealed the colonoscopy continued to be deferred until an authorized representative could be obtained to provide consent for the procedure. [See also W124, a] 2. [Cross refer to W212]. The facility failed to ensure that Client #3 received a timely Brain MRI as recommended. Interview with the QMRP and the LPN on November 7, 2007 at AM revealed the MRI with and without contrast which the Neurologist recommended for Client #3 on September 7, 2006 to rule out seizure activity and dementia had not been conducted due to the lack of an authorized representative to provide consent procedure. [See also W124, b]	{W 322}		

CIGNET HEALTH CENTER

PHYSICAL EXAM REPORT

12164 Central Avenue, Suite 200
Mitchelliville, MD 20721

4333-Old Branch Ave.
Temple Hills, MD 20748

Name of Patient MAHETEMB BAYEage 47 Sex M Date 07/25/07

Brief History and Physical examination A 47 year old male with past medical history significant for tve PPD in the past who is here for employment physical. His last CXR was in 2005 - NAD. O/E. Pt A&Ox3. BP = 120/70 pulse = 74 RR = 16 Temp = 97.4 CHEST: CTA ○ wheeze ○ rales ○ rhonchi; rest of PE-WNL

Lab report —

X-ray and EKG report CXR - 2005 → NAD

PPD Status Hx of tve PPD in the past.

Assessment and Recommendation/plan Patient is free of any communicable disease.

Name of Physician VINCENT OKEKE MD

Signature& Date 07/25/07

CIGNET HEALTH CENTER
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